FINANCIAL POLICY

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

Regarding Non-Insured Patients
Payment in full is due at the time of service unless prior arrangements have been made. Cash or check payments receive a 5% discount.

Regarding Insured Patients
The estimated non-insurance portion (co-pay and deductible) for treatment rendered is due at the time of service. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid on your account in 90 days, the balance will be expected in full.
We will gladly discuss your proposed treatment and answer any questions relating to your insurance; however, please understand:

- Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party in that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services *they* will not cover.

We accept payments by cash, check, Visa, MasterCard, Amex, & Discover. Information regarding extended payment plans is also available through *CareCredit*. Returned checks will be subject to an additional fee of $50. After 30 days, all accounts are subject to a Finance Charge of 1.5% of the unpaid balance and a billing fee of $3.00 will be applied for each statement sent for payment remittance.

A minimum charge of $75 may also be applied for any missed appointment or appointment not cancelled with a 48 hour notice.

We appreciate your trust and confidence in our office. Our goal is to always make your visits as pleasant as possible. If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for any professional services rendered. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses including reasonable attorney fees. I hereby authorize Levison Dental Group to release information necessary to secure the payments of benefits.

NAME (please print) _____ Date _____

SIGNATURE _____Date _____

PARENT/GUARDIAN (if minor) _____Date _____